DISABILITY PROCESS

The purpose of this informational handout is to provide you with a basic and general overview of the disability process.

1. Contact a Retirement Analyst in the Montgomery County Employee Retirement Plans (MCERP). The specialist will go over all of the information regarding the process and Retirements associated with a disability retirement. Please note that on average the process takes 4-6 months before a decision is reached. Complete and sign your Disability Retirement Application.

2. Compile all medical documentation for the last 5 years and forward to Disability Program Manager within 2 weeks of the appointment. If additional time is needed, contact Disability Program Manager for an extension of time.

   Montgomery County Government
   Disability Program Manager
   Attn: Sally Miller (Confidential)
   255 Rockville Pike, Suite 125
   Rockville, MD 20850
   240-777-5118
   240-777-5172 (Sally Miller – direct)

3. If you need to inquire regarding the status of your claim, contact the Disability Program Manager. The Retirement Team has no information on status.

4. Once all the medical documentation is received, along with all the appropriate completed forms, Disability Program Manager will prepare records for the Disability Review Panel.

5. The panel will meet within 60 days of the application date. The panel may schedule an Independent Medical Exam (IME).

6. The panel's recommendation is made within 30 days of meeting or 30 days after receipt of IME report.

7. The recommendation is then forwarded to Disability Program Manager.

8. Disability Program Manager forwards recommendation to County Attorney within 2 weeks for review and comments.

9. Disability Program Manager forwards comments, if any, to the Executive Director.

10. MCERP director forwards decision memo to CAO requesting final decision.

11. MCERP notifies employee of CAO's decision, along with appeal rights. MCERP will notify the employee's department of the final decision. If employee is awarded a disability retirement, then a retirement counseling appointment is scheduled to go over the Retirements.

Montgomery County
Application for Disability Benefits

NAME:_____ SSN: _____

ADDRESS:_____ Date of Birth:_____

_____ Email:_____

_____ Phone Number_____

Department: _____

Supervisor Name: _____ Phone Number: _____

Current Work Status: Full Duty / Light duty / Not at Work

Other: _____ Effective Date: _____

Retirement Plan: ERS / RSP/GRIP (circle one)

Union Status: MCGEO / FOP / IAFF / Non-Union (circle one)

Do you want the union to receive a copy of this application: Yes / No (circle one)

- I hereby make application for disability benefits and certify that the information I have provided is true and correct to the best of my knowledge.

- I understand that the disability benefit, if approved, will be effective on the earlier of the date that the CAO renders a decision or the date my sick leave and compensatory leave in excess of 80 hours is exhausted. I understand that this means that I may receive a telephone call advising me that I am retired and that my employment will be terminated as of that date.

- I understand I am responsible for obtaining any medical records from my personal physician to be submitted to the Disability Program Manager and that the manager will obtain any Workers' Compensation and Occupational Medical Services medical records for the Disability Medical Review Panel. Please be advised that these records will become property of the County and will not be returned to you.

Signature: _____ Date: _____

MCERP completes this section

Hire Date:_____ Job Class:_____(name) _____ (number)

Is this an Administrative Application? _____ If yes, attach all documentation provided by the department.

Notes:_____

_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

SCOPE

This Release for Medical Information is to support the application for disability benefits submitted on _____. Unless limits* are shown below, this release pertains to all of the following records: medical, mental and dental care, drug or alcohol use, prescribed drugs, employment and insurance coverage records.

This authorization is for the release of medical records from health care providers, hospitals, pharmacists, employers, and all other agencies or organizations. This includes insurers, Blue Cross-Blue Shield and prepaid health plans, Workers' Compensation administrators and Montgomery County Occupational Medical Section. Please send to the Occupational Medical Section, Office of Human Resources, by _____.
(Date)

* LIMITS: _____

AUTHORITY

I agree that the Montgomery County Government's Occupational Medical Section may see, or get a copy of, all records that pertain to _____, for the sole
(Name of Employee)
purpose of processing an application for County disability benefits. All such records will be collected for use in evaluating eligibility for disability benefits under the County's retirement laws. All records collected will be kept as retirement medical records, and will be kept separately from employee medical records.

This information is for the sole use of employees and agents of The Montgomery County Government who are engaged in the processing and evaluation of the application for disability benefits. Unless a law requires it, information will not be given in an identifiable form to any other persons unless I agree to its release in writing.

The Montgomery County Government will not incur any liability or assume responsibility for any expense incurred in complying with this request for medical records.

REVOCATION

I can revoke this authorization by giving written notice to the Occupational Medical Section of the Office of Human Resources. The notice will not apply to information released before the date the Occupational Medical Section has the notice. If not revoked, this form will be valid while the claim is pending but not for more than one year from the date it is signed.

I agree that a photocopy of this form will be as valid as the original. Anyone signing this authorization may have a copy of it, upon request.

Signed _____. Date _____

Relationship _____ (If signed by other than the employee)

cc: Employee
Occupational Medical